Action Plan

Service Name:	Ross Hall Hospital
Service Number:	00032
Service Provider:	Circle Health Group Limited
Address:	221 Crookston Road, Glasgow, G52 3NQ
Date Inspection Concluded:	20 June 2023

Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Requirement 1: The provider must develop and implement a SACT administration policy which reflects current Scottish legislation and Chief Executive Letter (CEL) 30 (2012) guidance (see page 10). Timescale – by 21 November 2023	Escalated to CHG Group Clinical Director and National Cancer Services Lead to review and revisit the overarching SACT Administration Policy incorporating Chief Executive Letter (CEL) 30 2012 guidance. Whilst CHG do not have an overarching SACT Administration Policy or Manual, it does have a comprehensive collection of policies which provide guidance on all areas of SACT administration to support the safe delivery of SACT and high standards of patient care. As outlined in our factual accuracy response, we are confident that the collection of policies that CHG has available supports the safe delivery of SACT and complies with the	21 November 2023	L Hodges DCS L Johnston CSM

	legislation and CEL. However, we have escalated this requirement to the CHG Group Clinical Director, Group Associate Medical Director and National Cancer Services Lead to develop and implement an overarching SACT policy/Manual so we can better evidence CHG compliance with the standards set out in CEL 30		
Requirement 2: The provider must ensure that an annual SACT report which covers Scottish SACT services is produced by the provider's SACT lead clinician and submitted and reviewed by the appropriate governance groups, as stated in Chief Executive Letter (CEL) 30 (2012).Timescale 21st November – 13th February 2024.	Within Circle Health Group our governance structure is such that SACT is a National Service which is then delivered at individual sites. As such reporting follows our Governance Assurance Framework for our ward to board reporting. The regional committees that review and report on SACT and report directly to the National Clinical Governance Committee Medicines Management Committee Patient Safety Incident Review Group Learning from Deaths Committee Member of these committees include- • Associate Medical Director, with responsibility for Cancer Services • National Lead - Cancer Services • Head of Pharmacy Cancer Services	21 November 2023	L Hodges DCS L Johnston CSM

	In addition to these committees, incidents and reactions relating to SACT are reported monthly in the Clinical Governance Report and Chief Medical Officer Report, which is presented to the Board. In response to the requirement, we will add to our routine reporting under our Governance Assurance Framework so that this now includes an annual SACT report for Scottish SACT services and include this among the responsibilities of our SACT lead. We will work with the National Lead: Cancer Services and Associate Medical Director to produce an annual SACT report which covers Scottish SACT services produced by the provider's SACT Lead.		
Recommendation a: The service should ensure that all members of staff are aware of all SACT related guidelines and processes.	There is a very robust process in place when new SACT Policies or Guidelines are introduced or developed. The National Cancer Services Lead has now also introduced the lunch and learns sessions to further raise awareness and provide further opportunity for learning and development. In addition to our current measures, we will also ensure that all members of staff follow current guidelines and processes relating to SACT. Any updates to guidelines, processes or policies will be discussed at the	21 November 2023	L Hodges DCS L Johnston CSM

	team meetings and documented in the team minutes and team Sessions as part of COS.		
Recommendation b: The service should ensure SACT dose adjustments have a rationale clearly and consistently recorded within the online chemotherapy prescribing record.	The SACT electronic prescribing platform iQemo requires the rationale for dose adjustment to be recorded on the electronic platform before the process is completed. iQemo therefore always records the rationale for dose adjustments as directed and advised by the patient's consultant oncologist who prescribes accordingly. The Clinical Nurse Specialist in Oncology continuously assesses and monitors patients' conditions and responses to treatment using the pre-treatment assessment tool aligned to the UKONs tool to monitor toxicity and reduce any associated risks of toxicity. In response to the recommendation, we will discuss further with the National Lead: Cancer Services and Associate Medical Director as the Lead Clinician and consider an IT (Information Technology) request to iQemo to facilitate additional free text box to record more robust details in relation to the consultants' dose adjustment decision and subsequent prescription of SACT.	31 October 2023	L Hodges DCS L Johnston CSM

Recommendation c: The service should ensure that copies of NHS multidisciplinary team meeting discussions, clinical letters and documentation of assessments by oncologists are consistently available for patients with any type of cancer within the Ross Hall Hospital patient care records.	Processes are in place at CHG Ross Hall hospital in which we ensure that all patients are discussed at an appropriate MDT meeting. This is audited in Cancer Services documentation National Audit. Evidence of MDT is provided and reviewed before treatment is commenced. In response to this feedback, we will work closely with the medical and administration team to ensure that post clinic outcome letters as well as MDT meeting outcome letters are routinely available consistently in all patient care records.	31 October 2023	L Johnston CSM
Recommendation d: The provider should ensure that the SACT lead clinician letter of appointment included roles and responsibilities of the post, reflecting those outlined for the role in Chief Executive Letter (CEL) 30 (2012)	The clinician with overall accountability and responsibility for oncology across CHG is the Group Associate Medical Director. In response to this feedback we have discussed this recommendation with the Group Associate Medical Director and National Lead: Cancer Services and asked that the roles and responsibilities of the SACT Lead clinician are outlined within the role profile of the Associate Medical Director who assumes the role of SACT Lead Clinician for the Scottish sites within CHG, in order to evidence compliance with the requirements of CEL 30. We do not employ consultants in the independent sector; the lead clinician role at Ross Hall is an advisory role only and represents	31 October 2023	L Hodges DCS L Johnston CSM

	Cancer Services on the Medical Advisory Committee. In response to this feedback the title of the local site SACT lead clinician will change to Ross Hall SACT Advisory Consultant. The roles and responsibilities will remain clearly defined within the Cancer Services Improvement Group document and will be issued to the relevant clinician alongside their letter of appointment to the SACT Advisory consultant role. This role encompasses the provision of support to the Clinical Services Manager for Cancer Care as well as support to the Executive Director and Director of Clinical Services in all matters relating to governance and safety of the SACT service.		
Recommendation e: The service should ensure a consistent approach and governance process is implemented which includes standardised headers, footers and evidence of approval for all SACT protocols (see page 11).	CHG has a standardised process is in place for all new and off-protocol requests. Consultants are required to complete the New or Off Protocol Request Form (CHG PHpol14 – Form01) for submission to the Head of Pharmacy Cancer Services. Protocols are written by experienced oncology pharmacists and reviewed by a second pharmacist prior to Consultant review and ratification. There is a protocol template used within Circle Health Group which includes standard	31 October 2023	L Hodges DCS L Johnston CSM

	headings, references, and document control section. The document control section states who developed, reviewed, and ratified the protocol. The protocol template is based on guidance provided in BOPA "Guidance on the contents of a SACT protocol" document published in April 2020. Each protocol is allocated a CHG Protocol Number and a Review Date (3 years after publication). The Head of Pharmacy Cancer Services maintains the protocol library and monthly, identifies protocols for review. A two-stage iQemo regimen development process has also been established to ensure that all SACT related treatment protocols/regimens are developed under a robust governance framework thus providing patient safety reassurance. The "Pharmacy Management of SACT" policy references the New or Off Protocol Request Form. In addition, when NICE (National Institute of Care Excellence) produces new or updated guidance there is a policy in place for the management of these.		
Recommendation f: The service should ensure that there is evidence of workforce planning for SACT pharmacy staff.	Escalated to CHG Group Clinical Director, Group Head of Clinical Governance and Improvement, Group National Lead: Cancer Services and Group Associate Medical Director.	31 October 2023	L Hodges DCS L Johnston CSM

	Pharmacy currently has their own designated workforce planning tool like that demonstrated on the day of the inspection for the nursing team. This is utilised to evidence the appropriate deployment of resources and manage staffing rotas. There is currently work underway to review the workforce planning tool used across the service, specifically within Pharmacy service to evidence appropriate staff utilisation and clinical skill mix to ensure the safe and effective dispensing of SACT. We have asked that they consider referring within any revised workforce planning tool to CEL 30 for Scottish sites administering SACT to be compliant with the requirements of CEL 30.		
Recommendation g: The service should update the mortality and morbidity meeting forms to include a section detailing explicit information about the management of any treatment toxicity, including information from other hospitals. This should be shared with the individual consultant and fed back to all oncology staff for shared learning.	The local Mortality Meeting form 'Death within 30 Days of SACT' has been reviewed and updated to include a section detailing explicitly the management of any treatment toxicity, including such information that may be reported from an NHS acute hospital that the patient may attend. This information may also be gathered from the patient, the GP, the patient's consultant or via communication from the hospital.	31 October 2023	L Hodges DCS L Johnston CSM

	At Ross Hall hospital we only deliver SACT for common cancers. Patients are continuously assessed for toxicity and all circumstances of toxicity relating to mortality would be investigated as a separate incident and recorded on our Incident Management portal. Any patent that dies unexpectedly within 30 days of administration of SACT would have a structured judgment review ("SJR") undertaken, which would look at all aspects of the patient care and treatment. The findings of the SJR are fed back to the consultant and oncology staff and are presented at the Patient Safety Incident Response Group and the National Learnings from Deaths Committee. At a local level, Ross Hall Hospital ensures these incidents are discussed at Medical Advisory Committee meetings, Clinical Governance Committee Meetings and at the quarterly Morbidity and Mortality review meeting. Further discussion would also be discussed at Cancer Services Group if required. Actions and learnings from investigations are shared as part of the Oncology Department team meetings and where required as part of formal Clinical Supervision. Information from an NHS acute hospital managing a patient toxicity would routinely be fed back through the system via the consultant		

	oncologist and shared learning would be disseminated thereafter. Circle Health Group has not reported a case of toxicity in the last 2 years.		
Recommendation h: The service should ensure nursing records include all evidence of how they keep up to date with new SACT treatments before these are implemented into clinical practice.	CHG Ross Hall have a comprehensive process by which our staff maintain competence and keep updated, including new protocols. Prior to the administration of any treatment • The team will continue to review the consultant referral/last clinic letter and communication from Consultant which outlines any specific medication or treatment/investigation requirements. • They will continue to review the CHG protocols and review any specific guidance documented. This will continue to be discussed with the hospital pharmacy team or the corporate pharmacy team. • In the absence of an established CHG protocol this will be escalated, and the pharmacy teams will establish one based on current best practice guidance. • The CSM Cancer Services will arrange for representation from the drug company to attend the unit with both staff and patient information to provide an overview of any specific administration and side effect	31 October 2023	L Hodges DCS L Johnston CSM

	management. We will continue to keep records of participation and attendance and uploaded electronically for review. • The CSM will continue to report via Clinical Governance Cancer Services Bimonthly Report on evidencing how information was obtained and shared when any new treatment is being introduced and how this is recorded on our staff training files. • Training records were shared openly at inspection and will now be updated to provide evidence of training in relation to each individual drug to provide greater clarity surrounding the implementation of new drugs. • Engagement with the pharmacy team and drug representatives was highlighted alongside the process whereby information re new treatment regimens is shared and this process will continue. • Clinical Management Guidelines are available for all staff to review.		
Recommendation i: The service should refer to the SACT day case risk assessment tool when designing the day case unit and undertake a formal risk assessment on completion of the work	The SACT Day case Risk Assessment Tool will be incorporated when working with the Architect and Builders when planning the new Oncology Day Unit and ensure that the plans are compliant with SHTMs and Current building regulations and guidance.	31 October 2023	L Hodges DCS L Johnston CSM

to ensure compliance with current environmental guidance.			

Name	LINDA HODGES
Designation	DCS
Signature	Linda Hodges
Date	28 / 09 /2023

Guidance on completing the action plan.

- **Action Planned**: This must be a relevant to the requirement or recommendation. It must be measurable and focussed with a well-defined description of how the requirement/recommendation will be (or has been) met. Including the tasks and steps required.
- **Timescales:** for some requirements the timescale for completion is immediate. If you identify a requirement/recommendation timescale that you feel needs to be extended, include the reason why.
- Please do not name individuals or an easily identifiable person in this document. Use Job Titles.
- If you have any questions about your inspection, the requirements/recommendations or how to complete this action plan, please contact the lead inspector.